

MODE = MEMORY TRANSMISSION

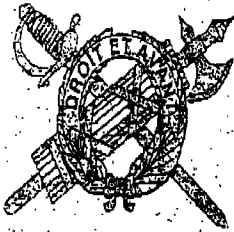
START=MAR-30 06:51

END=MAR-30 06:53

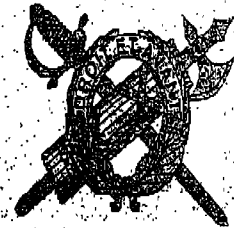
FILE NO.=267

STN NO.	COMM.	ABBR NO.	STATION NAME/TEL NO.	PAGES	DURATION
001	OK	*	997037508767	012/012	00:01:56

\*\*\*\*\* - \*\*\*\*\* - 7036075865- \*\*\*\*\*



# Department of the Army Office of The Inspector General



Legal Office  
&  
Records Release Office

2511 Jefferson Davis Highway  
Arlington, Virginia 22202-3912  
COMM: (703) 601-1093 DSN: 329-1093  
FAX: (703) 607-5865 DSN: 327-5865

TO: Mr. Tony Lombardo  
Army Times

FROM: Mr. DeCamp

FAX NUMBER: 703-750-8767

DATE: 30 Mar 09

NUMBER OF PAGES INCLUDING COVER SHEET: 12

SUBJECT: Army Medical Deployment Process

COMMENTS:

---



---



---



---

32



DEPARTMENT OF THE ARMY  
OFFICE OF THE INSPECTOR GENERAL  
1700 ARMY PENTAGON  
WASHINGTON DC 20310-1700



30 MAR 2009

REPLY TO  
ATTENTION OF

Records Release Office

Mr. Tony Lombardo  
Army Times, Deputy News Editor  
tlombardo@armytimes.com

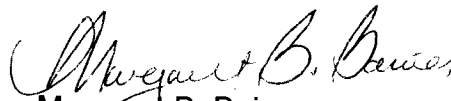
Dear Mr. Lombardo:

This responds to your Freedom of Information Act (FOIA) request dated March 26, 2009, for the Executive Summary of the DAIG Inspection of the Army Medical Deployment Process.

Enclosed is the Executive Summary of the DAIG Inspection of the Army Medical Deployment Process.

There are no fees assessable for the processing this request. If you have any questions concerning this response, please call Mr. De Ocampo or me at (703) 601-1093. Please refer to Case Number 09-295 when you call our office.

Sincerely,

  
Margaret B. Baines  
Deputy Legal Advisor

## EXECUTIVE SUMMARY

### Inspection of the Army Medical Deployment Process

During this last year, the Army has responded to numerous Congressional inquiries, media releases and complaints from Soldiers and veteran organizations regarding the growing perception that the Army is deploying Soldiers to Iraq and Afghanistan who are medically unfit. On June 18, 2008, the Secretary of the Army directed The Inspector General to conduct a 120-day compressed inspection of the Army Medical Deployment Process to assess medical and command policies and procedures that support a commander's determination of Soldier deployability. Seven Army Inspectors General augmented by six subject matter experts from the Army G1, the US Army Medical Command (MEDCOM), the National Guard (ARNG) and the US Army Reserve (USAR) conducted the inspection.

The team conducted individual interviews and group sensing sessions with 1,637 leaders, medical providers, Soldiers and civilians by visiting 24 installations/locations and forwarding questionnaires to 19 additional locations in CONUS and OCONUS. The team also reviewed applicable policies, regulations, Inspector General and GAO reports, and pertinent news releases. Findings and observations were developed from all relevant information and interviews, and recommendations along with Army "Best Practices" are provided in the report.

The inspection used three objectives to gauge the Army Medical Deployment Process:

1. Assess the effectiveness of medical and command policies and procedures as they pertain to profiles used to determine a Soldier's deployability.
2. Assess compliance with medical and command policies and procedures used to determine the deployability of Soldiers with medical profiles.
3. Assess training and understanding of medical and command policies and procedures used to determine Soldier deployability.

The inspection identified four major issues that should be improved to help commanders and medical providers arrive at the right decisions when assessing a Soldier's medical deployability status. These issues are: (1) synchronization and regular updating of Army policy and guidance with DoD and Joint policy; (2) Army-wide standardization of the Deployment Health Record (DHR), synchronization of Electronic Medical Recordkeeping (physical profiles), and interoperability of medical databases; (3) achieving an Army-wide comprehensive understanding of medical deployment policies to include the medical waiver process for deployment into Joint Areas of Operation; and (4) developing standardized medical readiness training and certification

programs for medical providers and leaders to increase their understanding. This report includes specific recommendations to address observed deficiencies.

Commanders, in coordination with medical providers, are doing their best to determine the medical deployability status of Soldiers; however, there is room for error due to the multiple sources of medical deployment policy and guidance; from Department of Defense (DoD) to Department of the Army (DA) to US Central Command (CENTCOM), which in some cases is inadequate, unsynchronized, or conflicting.

While Army Regulation (AR) 40-501 and Army G1 Personnel Policy Guidance (PPG) are the most commonly used policies, there are at least 13 other policies at varying levels that provide Soldier medical readiness guidance or requirements. The number of policies currently in existence increases the likelihood that Soldiers who do not meet medical deployability requirements may be deployed in violation of one or more policies.

The inspection revealed that medical deployment readiness policies are not sufficiently promulgated to the field. Our interviews indicated that many commanders and medical providers were simply unaware of crucial Army regulation updates and Combatant Command (COCOM) medical guidance from CENTCOM.

The inspections team found that COCOM-level medical requirements, such as CENTCOM Mod 8 and Mod 9, received formal staffing only with the Army Service Component Command (ASCC). Concurrence or non-concurrence with COCOM policies, without Headquarters, Department of the Army (HQDA) staff functional proponent review and comment, may have a larger strategic impact on overall policy and standards.

The inspection found that conflicting guidance exists regarding the final authority for Soldier deployability decisions. In large measure, commanders rely upon the expertise of medical providers when reaching deployability decisions. In potential cases where commanders and medical providers may disagree, Army regulation provides no clear resolution process. This lack of clarity may result in confusion and conflict regarding a Soldier's deployability determination.

The inspection team confirmed the wide spread use of the Army mandated Medical Protection System (MEDPROS) to track the medical readiness of Soldiers; however, the data in the system is not always timely or accurate. Furthermore, medical providers are using Armed Forces Health Longitudinal Technology Application (AHLTA), DoD's electronic health record but connectivity issues prevent timely record updates and AHLTA is not interoperable with MEDPROS.

The inspection team found that the Army does not provide standardized guidance for medical providers on issuing profiles and advising commanders on Soldier deployability. Even though most leaders have a working knowledge of how profiles are used, there is no standardized leader training on medical deployment policies. That said, most

commanders and medical providers indicated gaining "on the job" experience resolving medical readiness issues. Although no training requirements exist, most Soldiers expressed an understanding of the deployment decision-making process when leaders and commanders counseled them and explained the decision.

The following documents the findings, observations, and recommendations made by the inspection team:

**OBJECTIVE 1: Assess the effectiveness of medical and command policies and procedures as they pertain to profiles used to determine a Soldier's deployability.**

**Observation 1.1:** The Army does not have a single, comprehensive source listing all medical deployment and readiness guidance.

Recommendations:

a. Army G1 and The Surgeon General, subject to Assistant Secretary of the Army for Manpower and Reserve Affairs oversight, establish one source that contains all deployment standards, to include medical readiness and ensure that it is reconciled, synchronized and updated quarterly.

b. The Surgeon General in coordination with Army G6, establish a web-based knowledge management repository of medical deployment and medical readiness policies.

**Observation 1.2:** Unsynchronized COCOM-level medical requirements, only coordinated with the ASCC, may negatively impact Army deployment standards which contribute to confusion and conflict at the medical provider and commander level.

Recommendations:

a. Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA M&RA) coordinate with the Chairman of the Joint Chiefs of Staff (CJCS) to ensure that COCOM-specific medical deployment requirements are developed in conjunction with the Surgeons General.

b. Commanders, Army Service Component Commands, ensure appropriate HQDA staff coordination is accomplished during staffing of COCOM policies/procedures that may affect Army policies/procedures.

**Observation 1.3:** In some instances, medical readiness and deployment policies and regulations contain conflicting guidance and ambiguities, thereby creating interpretation issues for commanders.

Recommendations:

a. The Surgeon General amend AR 40-501 to eliminate confusion regarding deployment medical processing roles and responsibilities.

b. Army G1:

1. In coordination with The Surgeon General, establish a formal Army medical deployment waiver process, adaptable to specific Areas of Responsibility (AOR)/COCOMs, and publish to the PPG or appropriate regulation.

2. In coordination with The Surgeon General, update publications and forms, eliminating terms such as "NO-GO" and "Non-Deployable" and replace with "requires further evaluation" or "does not meet readiness requirements".

**Observation 1.4:** Army regulation does not clearly identify the commander as the final authority for Soldier deployability decisions.

Recommendations: Army G1:

1. Amend AR 600-20 and AR 40-501 to clearly designate the final authority who may determine deployability status when a Soldier does not require further medical evaluation.

2. Establish a deployment approval process to resolve disagreements between commanders and medical providers regarding deployability. Designate the appropriate level commander to approve deployments and deployment medical waivers.

**Observation 1.5:** The current Physical Evaluation Board (PEB) system is returning Soldiers "fit for duty" who are not worldwide deployable.

Recommendation: Army G1 change AR 635-40 to use "worldwide deployability" as a heavily weighted criteria in determining fitness for duty.

**Observation 1.6:** Army guidance on application of Soldier Readiness Program (SRP) processing is out of date.

Recommendations: Army G1:

1. In coordination with the Commander, Installation Management Command (IMCOM), update AR 600-8-101 to reflect current Army transformation and installation management procedures.

2. For Active Component, change the deployment SRP from D-30 to D-60 to allow time for commanders to identify and resolve Soldiers' deployment limiting medical issues.

**Observation 1.7:** Inconsistent resourcing and lack of a single, standardized SRP site on Power Projection Platforms (PPP) and mobilization sites cause inconsistent application of the SRP process.

Recommendations: Commander, Installation Management Command:

1. Continue efforts to standardize resourcing and capabilities through IMCOM's Common Levels of Support (CLS) initiative with emphasis on permanent SRP facilities at Power Projection Platforms and mobilization sites.

2. Add SRP capability to the IMCOM Installation Status Report; potential IMCOM core capability/competency that the Army needs to retain as an enduring function.

**Observation 1.8:** Most Reserve Component (RC) commanders and medical providers stated that the 90-day TRICARE eligibility is not sufficient to prepare RC Soldiers before mobilization.

Recommendation: Assistant Secretary of The Army, Manpower and Reserve Affairs/Army G1, in coordination with the Department of Defense Military Health System, extend the TRICARE eligibility timeline out to 180 days prior to deployment for alerted units.

**Observation 1.9:** The majority of installations visited stated that extensive communication (e.g. visits, Video Teleconference) between Mobilization Brigades, SRP sites and units contributed greatly to increased medical readiness and fewer "Release from Active Duty" (REFRAD) cases.

Recommendation: Commander, Installation Management Command, in coordination with Army G1; Commander, US Army Medical Command; Commander, Forces Command; Director, Army National Guard; and Chief, US Army Reserve, standardize pre-mobilization coordination.

**Observation 1.10:** Some installations have instituted deployment flight manifest checks to validate Soldiers' clearance through SRP.

Recommendation: Army G1 standardize final manifest checks to validate Soldiers' clearance as part of the SRP.

**Observation 1.11:** Implementation of Army Selected Reserve (SELRES) Dental Readiness System (ASDRS) expedited SRP and increased dental readiness.

Recommendation: Army Leadership continue to support the expansion of ASDRS to the Army Reserve.

**OBJECTIVE 2: Assess compliance with medical and command policies and procedures used to determine the deployability of Soldiers with medical profiles.**

**Finding 2.1:** Most reviewed DA Form 3349s (Physical Profile) provide unit commanders with sufficient information to make deployment decisions; however, a few are not in compliance with AR 40-501 because of administrative errors or incomplete information.

Recommendations: The Surgeon General/Commander, US Army Medical Command:

1. Implement the electronic profile initiative to require all profiles be generated electronically and distributed to Soldier's unit.
2. Place command emphasis on Medical Treatment Facility Commanders to enforce current profile policy until the e-profile has been implemented.
3. Develop and implement a training program on documenting physical limitations using the DA Form 3349 (physical profile) as part of the medical credentialing process.

**Finding 2.2:** Most unit commanders and a majority of medical providers at SRP sites were not aware of the requirement to request CENTCOM waivers for Soldier's medical conditions that do not meet CENTCOM medical standards for deployment.

Recommendations: Army G1:

1. In coordination with The Surgeon General, establish a formal Army medical deployment waiver process, adaptable to specific AOR/COCOM, and publish in the Army PPG or appropriate regulation accordingly.
2. Establish a process to enable the Army to track Soldiers deploying with approved medical waivers and early return/redeployment due to medical reasons.

**Finding 2.3:** Most installations/leaders use MEDPROS to track medical readiness; however, data accuracy and interoperability issues exist.

Recommendations: The Surgeon General/Commander, US Army Medical Command:

1. Implement e-profile initiative requiring all profiles be generated electronically through Medical Operational Data System-Medical Non-Deployable (MODS-MND), which updates MEDPROS automatically and distributes the profile to the Soldier's unit.
2. Enforce current policy that medical providers are to use and update MEDPROS.
3. Modify AHLTA to enable it to communicate with and update MEDPROS.

**Finding 2.4:** Slow updating of data within MEDPROS causes inaccurate reporting on Soldiers' medical readiness.

Recommendation: Commander, US Army Medical Command assess and improve the timeliness of data entered into MEDPROS.

**Finding 2.5:** Deployment health records at SRP sites and in Kuwait contained inconsistent and varying medical documentation.

Recommendations:

a. The Surgeon General/Commander, US Army Medical Command:

1. Consolidate the requirements for the contents of the deployment health record (AR 40-66, DA Pam 600-8-101, PPG).
2. Require hard-copy theater treatment records be added to the deployment health record and be input into AHLTA upon redeployment until providers in theater have access to AHLTA.

b. Army G1:

1. In coordination with The Surgeon General, update Army Regulation 600-8-101 and the PPG with consolidated requirements for the deployment health record.
2. In conjunction with Commander, Installation Management Command, ensure compliance with deployment health record requirements.

**Finding 2.6:** Many installations continue to rely on Soldiers hand-carrying their profiles as the sole means to inform the chain of command, in violation of AR 40-501.

Recommendations: The Surgeon General/Commander, US Army Medical Command:

1. Implement the electronic profile initiative to require all profiles to be generated electronically and distributed to Soldier's unit.
2. Place command emphasis on Medical Treatment Facility Commanders to enforce current policy that "copies of DA Form 3349 will be delivered by means other than the individual on whom the report is made".

**OBJECTIVE 3: Assess training and understanding of medical and command policies and procedures used to determine Soldier deployability.**

**Observation 3.1:** The Army does not have a standardized program of instruction for medical providers on issuing profiles and advising commanders on Soldier deployability.

Recommendations: Commander, US Army Medical Command:

1. Develop a Program of Instruction on profiling and medical deployability requirements for inclusion into Army Medical Department (AMEDD) Medical Officer Courses.
2. Develop a web-based distance-learning program for medical providers not receiving AMEDD profiling and medical deployability requirements training.
3. Develop a web-based provider certification program that ensures that all newly assessed medical providers know and understand Soldier medical readiness and deployment standards.
4. Consider implementing the Fort Campbell medical provider mentoring and training program at all installations for the professional development and training of medical providers.

**Observation 3.2:** Most commanders have a working knowledge on how profiles are used in the deployment determination process; however, few have a detailed knowledge of pertinent deployment policies.

Recommendations:

- a. Commander, US Army Medical Command:
  1. Develop a leader's guide to Soldier medical readiness and pertinent medical deployment policies.
  2. Develop a web-based distance-learning product on Soldier medical readiness and pertinent medical deployment policies for Army leaders E5 and up.
- b. Commander, US Army Training and Doctrine Command (TRADOC): In coordination with Commander, US Army Medical Command, determine viable training opportunities and incorporate MEDCOM-developed medical readiness and medical deployment policy training products into applicable leader courses.
- c. Commander, Installation Management Command: Incorporate MEDCOM-developed medical readiness and medical deployment policy products into local CDR/1SG Courses.
- d. Director, Army National Guard and Chief, US Army Reserve: Incorporate MEDCOM-developed medical readiness and medical deployment policy products into applicable leader courses.

**Observation 3.3:** Soldiers have a limited understanding on how profiles impact deployment decisions.

Recommendations: Army G1 incorporate into AR 600-20, chapter 5-4, the requirement to counsel all Soldiers with deployment-limiting conditions that affect their deployment status.

## OTHER RELATED ISSUES:

**Observation 1:** Untimely scheduling of the Automated Neuro-Psychological Assessment Metric (ANAM) requirement for BDE sized elements conducting SRP may lead to disruption of Soldier processing.

Recommendation: Commander, US Army Medical Command, synchronize the administration of the ANAM and require its completion prior to units conducting the final deployment SRP.

**Observation 2:** Soldiers with medical conditions are receiving assignments from Advanced Individual Training (AIT) and other duty stations that require medical treatment and/or resolution before the Soldier meets medical deployment standards.

Recommendation: Army G1 review current policy on Permanent Change of Station (PCS) requirements from AIT or between duty stations for Soldiers with medical issues.

**Observation 3:** Some RC Soldiers processing through SRP processing sites were receiving Veterans Affairs (VA) disability; however, there is no policy link between VA disability and Army fitness for duty, or disability and active duty pay.

Recommendation: Assistant Secretary of the Army for Manpower and Reserve Affairs/Army G1, in conjunction with The Surgeon General; Director, Army National Guard; and Chief, US Army Reserve; coordinate with the Department of Veterans Affairs to develop and implement policies and procedures to inform the Army about Soldiers receiving VA disability benefits.

**Observation 4:** Some Soldiers are identified as having been REFRAD on multiple occasions and re-mobilized with no resolution to the cause of the initial REFRAD.

Recommendation: Director, Army National Guard and Chief, US Army Reserve, subject to Assistant Secretary of the Army for Manpower and Reserve Affairs oversight, develop procedures to track completion or adjudication of REFRAD'd medical issues to reduce Soldiers re-mobilization with same issue.